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ABSTRACT

Teenage parenting and pregnancy is discussed in terms of incidence, health consequences, effect on teenage growth and development, social and economic costs, and existing programs sponsored by DHEW (Department of Health, Education, and Welfare). (SBH)

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Homebound Teenage Parenting

Paper

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Teenage Parenting

Problem:

One of the primary health problems of individuals under 19 years of age in the United States today is teenage pregnancy. In the year 1974, over 608,000 girls 19 and under carried infants to term in this country. This constituted:

(A) Almost 20% of all live births;

(B) Over 26% of the low birth weight infants;

(C) Greatly increased health risks to the mother and infant resulting from the teenage pregnancy compounded by:

(1) The disruption of schooling and,

(2) The likelihood of subsequent economic dependence.

Special Elements of the Problem:

Increasing numbers of very young women ages 10 to 14 are becoming pregnant, an 11.1% increase from 1961 to 1968 and a 30% increase from 1968 to 1973.

The number of children born to girls under 15 years of age increased by 27.4% during 1961-1968 and by 29% during 1968-1973

Age Group	Increase from 1961 to 1968	Increase from 1968 to 1973
<15	27.4%	30.0%
15-17	8.5%	23.3%

Age Group	Number of Births in 1961	Number of Births in 1973
<15	7,000	13,000
15-17	178,000	238,000

(1)

Health Consequences:

There are increased health risks for pregnant girls under 15 years of age.

Until relatively recently, it was assumed (on the basis of inadequate statistics and inaccurate analysis of available data) that immaturity did not carry with it any increased health risks for mothers or infants. This erroneous conclusion

came about in part because statistics on childbearing were not maintained according to specific age groups. The practice of aggregating all teenagers into one age group continues to make analysis imprecise since pregnancy in older teenagers (18-19) carries less risk than it does in younger women. In addition, statistically, pregnancies in older women contribute disproportionately to the total of teenage pregnancies.

It is now known that pregnancy in girls 15 years and under carries a considerably greater risk for the mother and her infant. In the case of the mother, this statement is based on higher incidences of toxemia, anemia, contracted pelvis, and prolonged and premature labor. In the instance of the child, the risks include prematurity and high paranatal and infant mortality. The incidence of low birth weight infants is two times higher among these deliveries than it is in a national cohort of all pregnancies over a given period of time.

Effect on Teenage Growth and Development:

The average age of menarche in the United States is 12.8 with 2 standard deviations encompassing the years 10 to 16 years of age.(2) At this time the girl still has not achieved her full "linear" growth.

Evidence comes from the observation that regardless of their specific chronological age, girls under 16 years of age who conceive within 24 months of menarche produce twice as many low birth weight infants as do mothers under 16 who conceive later than 24 months after menarche.(3)

The possible effect which pregnancy may have on the physical growth and development of the teenager is poorly understood. Information available is inadequate concerning the hormonal changes in the female which control "linear" growth and the effect which pregnancy has upon this phenomenon. It is known that the administration of estrogens to growing girls accelerates epiphyseal maturation and if continued causes premature fusion.

Social and Economic Costs:

The social costs of teenage pregnancy are difficult to measure precisely, but teenage parents are more likely to be "economically disadvantaged, ambivalent about child care, less skilled and under stress of no marriage or a new marriage." Mothers under 18 are less likely to possess the nurturing skills necessary to ensure maximum intellectual and emotional development of the infant. The adverse psychological effects on the mother are great as evidenced by the relatively high risk of later suicide among women who become pregnant during adolescence. Marriage appears to be no solution to these problems: Fifty percent of all teenage marriages result in divorce within five years.

The adverse economic consequences of teenage pregnancies have not been adequately documented although it is clear that these women and their partners are much more likely to drop out of school and to be forced to accept low-paying positions. Alvin Schorr has estimated that the single best predictor of the ability of a young woman to be economically self-sufficient is the age at which her first pregnancy comes to term: The younger she is the less bright her future.

Existing DHEW Programs:

During the past ten years and in particular the last five years, the Department of Health, Education, and Welfare, has been involved in two aspects of teenage pregnancy: Prevention and assistance to the teenage mother wishing to carry her infant to term. The office of maternal and child health has expanded its role in delivering medical services to teenagers and their infants by funding comprehensive school-based programs which address the social, economic, educational and medical needs of teenage parents and by conducting studies to evaluate the effectiveness of such programs. Special emphasis has been placed on reaching teenagers through existing family planning services. Despite the increase in availability of contraceptive information and services to this age group, teenagers still face substantial barriers when they seek to prevent pregnancies.

The Office of Education at one time served as the lead agency for DHEW and in that capacity provided staff for the now defunct new interagency task force on comprehensive programs for school-age parents. Continued financial and staff support has been provided by OE for technical assistance to comprehensive programs and a special OE/OCD project to develop and introduce "education for parenthood" programming within the schools.

OE has identified over 600 local programs which provide some assistance to pregnant teenagers. An estimated 300 programs provide comprehensive services. Evaluations of several of the most comprehensive programs demonstrate their short-term effectiveness in improving the health status of the woman and infant and in decreasing the incidence of school dropouts and repeat pregnancies. Their long-term effectiveness is not so clear. After the women leave a program but while they are still teenagers, a large number experience repeated pregnancies, drop out of school and do not attain economic independence.

Many types of Federal assistance are available for individual components of comprehensive programs although the primary sources have been Title XX of the Social Security Act, Title III of the Elementary and Secondary Education Act, the Adult Education Act, the Vocational Education Act, Title V, Maternal and Child Health Service, and Title X, Family Planning. Even if funds are available, community groups still need assistance in locating the appropriate sources of State and Federal monies. To this end, OE funds technical assistance projects designed to develop State and local mechanisms to assist commmunities in the implementation of their own programs.

A survey of 111 cities that provide special programs for teenage girls has shown that only nine cities reported having a caseload of over 500 pregnant teenagers and 48 cities reported serving less than 100 pregnant teenagers. Given the increasing numbers of teenage pregnancies, it is unclear whether these figures reflect decreased demand or the inadequate capacity of current programs. It may be that the need for special categorical programs has diminished and most women can now remain within a regular school program.

Even if an academic program is available, the health needs of these women often are not met by current third party payment systems including medicaid. It is reported that in an increasing number of states (29 at present) poor women who are pregnant for the first time are not eligible for medicaid-supported prenatal care because they are not eligible for welfare until the child is born. Twenty-five states provide coverage for the unborn child, and seven additional states provide services to all financially eligible persons under 21. Therefore, "poor"

teenage mothers would be eligible for financial assistance for medical care in only 32 states. Assistance through medicaid would not be available in 8 of the 10 states with the highest medicaid expenditure (California, Illinois, Michigan, Pennsylvania, Texas, Ohio, New Jersey, Wisconsin).

Where Do We Go From Here?

1. Become familiar with alternative school programs in your school community.

2. Become aware of the scope of the problem in your community.

3. Become aware of the magnitude of the local problem.

4. Be ready with a program to assist the retarded teenager who becomes involved in a situation of need.

[1]Menkin, Jane, "The Health and Demographic Consequences of Adolescent Pregnancy and Childbearing," paper presented at the Conference on the Consequences of Adolescent Pregnancy and Childbearing held in Bethesda, Md., October 29-30, 1975.

[2]U. S. National Center for Health Statistics, Age of Menarche, Series 11, No. 133, November 1973.

[3]Stine, Oscar, et al, "Juvenile Pregnancy: Role of Physiologic Maturity," Maryland State Medical Journal, March 1971, p. 52.